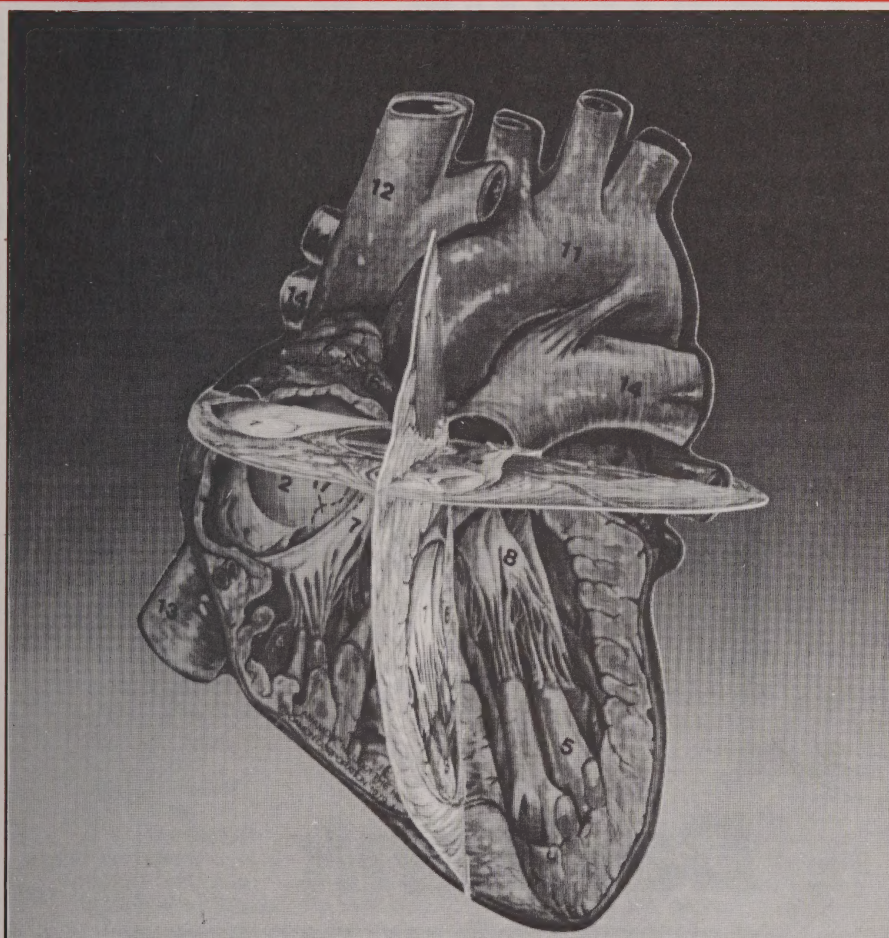
# The Hampden Hippocrat

February 1981

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# DISTRICT MEETING of the HAMPDEN DISTRICT MEDICAL SOCIETY

**DATE:** Tuesday, March 3, 1981

**PLACE:** Marriott Hotel
Springfield, Massachusetts

**BUSINESS MEETING:** 6:00 p.m.

**SOCIAL HOUR:** 7:00 p.m.

**DINNER:** 7:30 p.m.

**SPEAKER:** Daniel T. Cloud, M.D.,
President Elect
American Medical Association
Pediatric Surgeon fromPhoenix,
Arizona

**TOPIC:** "The A.M.A. Today"

Spouses invited. Refer to the Newsletter in mail.

If you must cancel your dinner reservations, call the office before noon on March 3, 1981. If the cancellations are not made you will be billed for your dinner.

Smoking in designated areas only at dinner.

THE HAMPDEN HIPPOCRAT

·1942·

FEBRUARY 1981 VOL. XXXVII NO. 2

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The official bulletin for The Hampden District of The Massachusetts Medical Society.
Founded in 1942 by Edward P. Bagg, Jr., M.D. and William A. R. Chapin, M.D.

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THE HAMPDEN HIPPOCRAT IS PUBLISHED MONTHLY EXCEPT FOR JULY AND AUGUST.
THE OPINIONS EXPRESSED IN THIS BULLETIN ARE THOSE OF THE WRITERS AND DO NOT REFLECT THE OFFICIAL VIEWPOINT OF THE HAMPDEN DISTRICT MEDICAL SOCIETY UNLESS SO STATED.
ALL COMMUNICATIONS SHOULD BE ADDRESSED TO VIVIAN M. PURDY, HAMPDEN DISTRICT MEDICAL SOCIETY, 1414 STATE ST., SPRINGFIELD, MASS. 01109; TELEPHONE: 736-0661.
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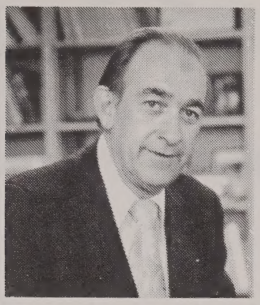

*J.J. SIRAGUSA, JR., M.D.*
*President*

# PRESIDENT'S PAGE

## *Alternative Sources Of Medical Care*

Back in the 60's our Legislature enacted Medicaid in response to the pangs of conscious of the general public because the medically needy were being subjected to the indignities of clinic and hospital based care. Now the medically indigent are filling our private offices and the middle class Americans are rapidly seeking out care that is provided by the HMO's, satelite groups, emergency rooms and a variety of other sources of care which do not call themselves clinics but are essentially just that. The public is being sold on the concept that more comprehensive less costly care can be provided through these groups. This concept represents a virulent threat to the private practice of fee for service medicine.

The most popular group is the Health Maintance Organization, which has labeled itself a Pre-Paid Medical Group. Some faulty semantics are inherent in these terms. I see no way in which a Health Maintance Organization maintains health any differently than you and I do in our private practices. Pre-Paid simply refers to the fact that the money is paid to the medical providing organization rather than to an insurance company as an insurance premium.

As you all know, the HMO concept started in California with Kaiser Corporation in an attempt to provide high quality medical care in a cost efficient manner. They set up a self insured organization and hired their own closed panel of physicians to provide care. Statistics have proven that they succeeded. The medical care provided by Kaiser Permanente has been documented as being of good quality and statistics have proven that they have provided this care at a much lower cost.

The concept behind a HMO is that one combines the insurer with the provider of care. If the provider is cost conscious and can provide care in a cost efficient manner he is rewarded by the insurer with an annual bonus. It has been proven in numerous such organizations tha the cost conscious provider need not compromise on the quality of care. The HMO concept has attracted the attention of government and health care providers and has become particulary attractive to industry that pays such a large amount of money for health costs.

Many hospitals are getting onto the HMO band wagon. They are setting up hospital based and satellite clinics that are closed paneled and manned by salaried physicians. Hospital Emergency Rooms are similarly used as another means of providing ambulatory care.

Methods of reinbursment are a disturbing factor. Many charge what is referred to as a "Facility Fee". This is a charge for use of the premises. The end result of this is that the charge for a patient visit ends up being twice what it would be in the private practicioner's office. They then apply a sliding fee scale which has great charm and attraction to the consumer public. The mathematics of this situation is obvious. Another disturbing fact is that the total cost for operation of these facilities is frequently subsidized by hospitals, inusurance companies or the government from revenues that are not generated in the facility.

All of the above represent a risk and a challenge to open-ended, fee for service private practice.

What can we do about all this? Certainly we cannot critize "motherhood and apple pie". When these facilities are providing a needed service in an underserved area or in a manner that is more cost efficient than can be provided by the private practitioner there existence is certainly justified. It is our claim that open competition is to everybodys advantage, so that we certainly cannot critize any of these facilities simply because they are competitive. We can, however, critize unfair methods of reimbursement, in equitable government subsidization and cross subsidization. A number of the committees of your medical society are addressing some of the above mentioned issues and are accumulating data and knowledge that will enable us to address these problems and cooperate with the State Medical Society in an effort to correct some of these inequities.

Our health care foundation has spent the last 7 years carefully researching the alternatives to other HMO prototypes. It has developed "Healthguard". We would do well to support Healthguard. It provides an open-ended fee for service method of "Pre-Paid" care which is marketable to industry and other group applicants in competition with the closed panel, salaried physicians type groups.

Most of us are devoted to the American, free enterprise system of medicine which has provided the world with the higest quality of medical care ever known to mankind. "Organized" medicine is trying desperately to preserve this system. Let us not sit back and critizize organized medicine. Let us, rather, support it, join it, contribute to it. Organized medicine is our team. Stay with it. □

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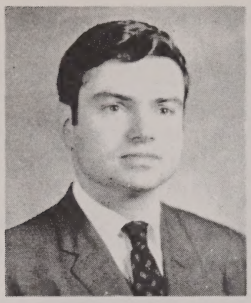

# HEART

Howard M. Ledewitz, M.D.
President
Western Massachusetts Division
Massachusetts Affiliate
American Heart Association

## A SERIOUS HEALTH PROBLEM

The impact of heart disease on our population is catastrophic. During the last ten years, over 51% of all deaths in Massachusetts resulted from some form of heart disease. Over 40 million Americans suffer from some heart disorder including hypertension, angina, stroke, congential defects, rheumatic heart disease, and other problems of coronary artery disease. The cost to this country is overwhelming -- over $46.2 billion dollars annually in lost productivity and permanent disability as well as the costs of health insurance, hospital care and medications. Solving this enormous health problem must remain a leading priority of both the private and public sectors.

Recent statistics show a 30-year decrease in deaths due to: Rheumatic Fever (down 82%), Hypertension (down 81%, Stroke (down 42%) and Heart Attacks (down 12%). However, the problem remains a serious one. Heart disease in the nursery affects 25,000 newborns each year. Younger people suffer from heart disease and stroke at a staggering rate; nearly 25% of heart disease related deaths happen to those under age 65. Heart disease kills nearly 1,000,000 people annually, more than all other causes combined!

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## A RECORD OF ACHIEVEMENT

The American Heart Association in Massachusetts has raised nearly $12 million dollars in the last five years to support a variety of activities. The American Heart Association has invested millions of dollars in Massachusetts in recent years to support promising research projects. This research has developed or improved many valuable accomplishments such as the pacemaker, artificial heart valves, and new medications for heart disease and hypertension.

## THE STARTING POINT - BASIC RESEARCH

The American Heart Association funds basic research. Each research project produces findings that contribute to the increasing body of knowledge that saves lives. Many Heart-sponsored researchers helped to understand the factors involved in high blood pressure and develop newer treatments.

Unfortunately, sufficient funds are not available. More and more researchers are leaving the field because research funding has become scarce. In Massachusetts, only 40% of approved research projects received funding during 1974 through 1979.

## THE CHALLENGE OF THE 1980's

Reducing the staggering number of lives lost each year to heart attack and stroke must be the challenge of the 1980's. The American Heart Association must help to discover cures for heart disease that will be readily available, relatively inexpensive and easy to deliver. Some of the priorities for the 1980's have been established to meet the Heart Association's public and professional obligations. These include:

1. Improving preventive cardiology to better identify and control those with actual and potential heart disease.
2. Providing increased support for research investigators in the laboratory.
3. Influencing Americans to modify their cigarette smoking and dietary habits.
4. Reducing the prevalence of uncontrolled high blood pressure.

You can help the Heart Association through your time, talent and money. You can make a contribution, memoralize or honor a loved one, conduct a special event or participate in our planned giving and bequest program. □

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# CROSSING OF THE CROSSROADS for the Springfield Academy Of Medicine

"The Springfield Academy of Medicine is at the Crossroads." This quote was written in our Hampden Hippocrat in November 1965. It has taken fifteen years for this to occur and the crossing is at hand. We would like very much to present this material on the Academy that may help our members determine which road to send the Academy.

At our last district meeting, Dr. John Carey informed us that the current funds of the Academy will be exhausted in the near future. The only possible means for the Academy to survive is by an affiliation with the Hampden District Medical Society. There are no other sources of sound funding to permit the Academy, particularly in its library role, to continue.

If the Academy does not affiliate with the Medical Society the Academy will cease to function and the assets would be disposed of "Given" to another organization holding the same IRS tax status (501 (c) 3) as the Academy. This simply means that the Medical Society could not receive any of the property of the Academy. They do not hold an IRS Educational Status.

With this in mind, what is there regarding the Academy which is important for us to be aware? Some of these would be Heritage, Historical Collection, Library, and its importance to our Community. Let us give some thought to these areas.


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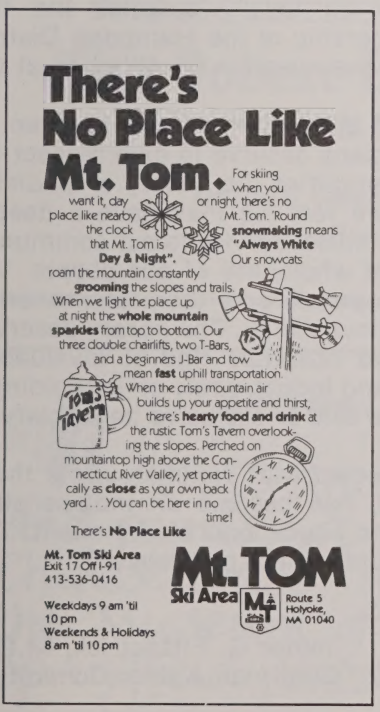
Incorporated in 1907, the Academy was founded because of the need for post-graduate education of physicians and the need for a medical library for the community. The Society, organized in 1840, concentrated on the non-clinical matters, the ethical and socio-economic problems of the day. Education fell under the exclusive aegis of the Academy.

From its beginning the chief purpose of the Academy had been post-graduate education for the physician. Nevertheless, we find that earlier in the history much of its efforts were also directed at political and socio-economic problems. A certified Milk Committee appointed in 1909, a fight against a Chiropractic Act in 1932, and a questionnaire against doctors who were habitually on the radio in 1935. How about that!

The Academy flourished in its middle years!Membership reached a high of 350. Over 500 scientific meetings were held that first fifty years, addressed by a great number of prominent speakers. The guest book reads like ''WHO'S WHO of GREAT SCIENTISTS''. Meetings were ''Black Tie'' events and during these years the Academy contributed greatly to the medical advancement and health of the public in the Greater Springfield area.

The Academy Library has grown in importance through its years of existence. Beginning in 1915 with several medical books borrowed from the Springfield Library Asociation. it now has the largest collection of medical books and journals in this half of the Commonwealth.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Important also is the historical collection, much of which is irreplaceable. Donated mostly by the early members of the Academy you will find a 1600 copy of "FALLOPPII Mytinensis, Phyficiac Chirurgipraeclarifsimi" Gabrielis, a collection of New England Journal dating back to vol. 1, 1812 (then called the New England Journal of Medicine and Surgery and Collateral Branches of Science) Major's "Hippocrates and Isle of Cos" just to mention a few of these early works.

On the walls of the library hang the six life-size paintings representing 300 years of medical history in the Connecticut Valley. Painted by Harriet Ellis in 1936 as the medical contribution to the 300th. birthday of the City of Springfield. A showing of these paintings and many of our medical artifacts was presented by the Science Center at Smith College during inter-session in 1979. So popular was this display that a request for an additional month was approved.

The present library has over 30,000 vols. and currently receives 183 journals. A most up to date textbook collection surprises many who have not used the reading room regularly.

The collection is important but the presence of Millie Martin as Academy librarian has been the greatest gift the library has to offer. A 1980 FACT SHEET of activity at the library for physicians and hospitals is included in this issue. It emphasizes the library importance and why we should preserve it.

Our committee has worked on various aspects necessary for the Springfield Academy of Medicine to affiliate with the Hampden District Medical Society. We believe that a practical, functional, organizational arrangement has been developed which legally satisfies the IRS status-quo of the Academy. The membership of the Hampden District Medical Society will be presented with the question of affiliation at the March meeting.

The committee feels that a vote of affirmation should be given by the Society. We believe that we physicians deserve to give respect for the heritage of the Academy which exemplifies the history of medicine in our area. By giving this respect we feel we may have a deeper appreciation of our current role in the medical service to our community and the hope for the future health and wholeness of our people. We physicians deserve to continue to be responsible for the preservation of our professional lineage in the Connecticut Valley. The library deserves our support. Physicians, dentists, and hospitals find it invaluable. Students find it exceptional, business and industry rely on its holdings. In short, our profession is no longer the sole or exclusive beneficiary of our Academy Library.

Ten years ago our loved and respected Max Millman wrote these words. "This central facility, in fact, has become an indispensible ingredient of our total civic, cultural, and educational environment. The chief responsibility for its support remains with us physicians."

I CANNOT SAY IT BETTER. □

James G. Fitzpatrick, M.D.
Chairman AdHoc Committee

# *1980 Fact Sheet At The Academy*

1. Members purchased over $5,000.00 in textbooks. At 10% discount saving $500.00.
2. Members asked for 86 searches. Computer searches would average $15.00 and they are not capable of searching beyond a certain period of years. These searches on computer would have cost members near $1,300.00.
3. For the above searches, lists of over 700 citations were sent to members for their selection. From those chosen photocopies of 7,500 pages were mailed to these members. Ten cents per sheet and postage totals over $1,000.00.
4. Seventy-four textbooks were sent to members anc. another 400 were signed out at the library.
5. The Academy borrowed 63 reprints from journals not owned at the Academy for members.
6. There were 261 reference questions from physicians or physicians offices.
7. Over 200 transactions were completed for our sustaining members.

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HOSPITALS:

1. The Western Massachusetts Health Information Consortia (Hospital library group) Chairman, Marilyn Rivers, is quoted from a recent release to all hospitals, "The Academy and, particularly Millie Martin, have been valuable resources for us, not only for inter-library loan, but for assistance with all aspects of Library service. Millie has contributed much to the education of Health Science Professionals."
2. Three hundred ninety requests were filled for hospital inter-library loans or reference.
3. Untold phone calls from struggling hospital librarians seeking assistance and how to's.

STUDENTS AND GENERAL PUBLIC

1. Students from the area schools of higher education find the Academy a most useful resource. You will often find users from U. Conn and U. Mass Medical Schools as well as the local institutions.
2. A letter from Elise Feeley, Reference Associate of the Pine Point Branch of the City of Springfield Library writes "The loss of this information center, which has consitently showed itself to be unimpeachable both in terms of service and fiscal responsiblility, as the Academy has, would greatly effect services to the citizens of Springfield.

# Springfield Academy Of Medicine Meeting

Melvin J. Steinhart, M.D. Albany Medical College

TOPIC:

Psychosomatic Disorders of Patients who have Physical Complaints by no Organic Pathology

5:00 p.m. - 6:00 p.m. on Tuesday, March 3, 1981 at Marriott prior to regular District Meeting of the HDMS.

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# DISTRICT MEETING

The January 13, 1981 District Meeting was called to order by Dr. Siragusa, President at 6:10 P.M. There were 84 members present.

The minutes of the November 25, 1980 meeting were read and approved. The highlights of the January 6, 1981 Executive meeting were discussed in the meeting.

## ANNOUNCEMENTS

The Putnam Vocational High School has been graduating qualified practical nurses for 30 years. Because of Proposition 2½ these classes may be eliminated. Support is needed from local physicians. Further information can be obtained from the office of the HDMS.

The next District Meeting will be held on Tuesday, March 3, 1981 at the Marriott Hotel. Dr. Cloud, President Elect of the AMA will be guest speaker.

## NEW BUSINESS

Dr. Pincus, representing the Massachusetts Society of Eye Physicians and Surgeons read resolutions on their behalf. These were submitted and discussed separately. He asked for HDMS support, Dr. Siragusa, President, passed the gavel to President Elect, Dr. Stoddard so he could speak on behalf of this resolution. Dr. Pincus elucidated further on the resolutions. Resolution 1 was passed unanimously by the members present. Resolution 2 was passed unanimously by the members present. Letters to this effect will be sent to the Society of Eye Physicians and Surgeons.

Dr. Fitzpatrick gave an update on the progress of the proposed merger of the HDMS and the Springfield Academy of Medicine. He gave much of the historical segment and said "This is a Heritage That Needs to be Preserved." He paid Mrs. Martin, the librarian a tribute for her many years of devotion to the library. He indicated the great need for this facility in the Western part of Massachusetts to the hospitals,

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colleges, schools, as well as the physicians and the Springfield Health Department. Dr. Carey, Treasurer for the Academy gave a financial report with an estimate of the assets. Dr. James Allan, Chairman of the by-laws committee will meet with Dr. Fitzpatrick to review HDMS by-laws for any necessary changes. The Hampden Hippocrat will carry information to the members on more information. It is hoped that this will be voted at the March 3, 1981 meeting.

Dr. Remsberg, Treasurer of HDMS presented the budget and dues recommendation for 1981-82. This billing of dues has been changed to January 1st to coordinate with the billing of the MMS. A motion was made to maintain the dues at $115.00. This motion was passed by the members present.

Dr. Metz, Chairman of the Membership Committee gave a short report. He said there were three groups of non members. 1. Don't want to join, 2. Apathetic and 3. Major objection; society does very little for them and for medicine, on the state level, A.M.A. or district. He plans a meeting for the following day.

A delicious capon dinner was served.

Dr. Guardione was recognized for bringing two residents to the meeting.

Dr. Siragusa introduced Mr. John Larkin Thompson, President of Blue Shield of Massachusetts. His topic was "Blue Shield in the 80's". He stated that Blue Shield, "like in a fish bowl" is regulated by the Insurance Commission of Massachusetts. There is a movement in Massachusetts to merge the "Blues" as in many other states.

There were many questions from the members present.

Mr. Thompson's presentation was very candid.

The meeting was adjourned at 9:30 P.M. □

William W. Walthall, Jr., M.D.
Secretary

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# *Highlights Of Executive Meeting January 6, 1981*

Meeting called to order at 7:40 P.M. by President Siragusa. Dr. Carey, Treasurer of the Springfield Academy of Medicine and Dr. Fitzpatrick discussed the financial arrangements that have been studied for the suggested possible merger of the Academy and the Hampden District Medical Society. The historical value of the Academy was discussed.

Dr. Remsberg, Treasurer discussed the proposed budget for 1981-1982.

Mrs. Condon, Auxiliary representative to the Executive Committee reported some responses from Auxilians regarding attending meetings of the H.D.M.S.

The Allen Photographic Corporation are to come east again to take pictures of the members of H.D.M.S.

The two resolutions proposed by the Ophthalmologic Society regarding limitations of independent non-medical practitioners prescribing or applying drugs will be discussed at the District meeting.

The meeting was adjourned at 9:36 p.m. □

## *In Memoriam*

Dr. Benjamin Schneider died on January 6, 1981 in Mercy Hospital.

Born in Boston he moved to Monson in 1941 to practice Genera Medicine.

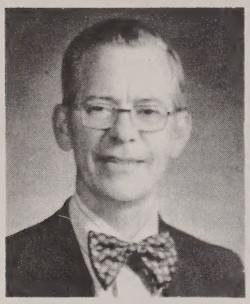
He graduated from Tufts Medical School and did his residency in Springfield and Wesson Hospitals from 1932 until 1934.

Dr. Schneider was the Medical Examiner for the First Hampden District. He served as Chief of Staff of Mary Lane Hospital in Ware and was a Monson school physician.

He was a charter member of Rotary Club, a corporator of Monson Savings Bank and a member of Day Spring Lodge of Masons and First Church.

Dr. Schneider was a member of the A.M.A., Massachusetts Medical Society, Hampden District Medical Society and the Academy of General Practice.

Deepest sympathy is extended to his wife, Rita and their children. □



# *AMERICAN MEDICAL ASSOCIATION MEETING*

The 1980 Interim meeting of the A.M.A. was held in San Francisco, December 7-10. I arrived a day early to attend the Medical Services Conference on HMO-IPA's. We heard of some successes and some failures but most of the optimism was based on future projections rather than current results. Although there are hundreds of operating HMO's thirty five per cent of the total enrollment is in the Kaiser Foundation, and six per cent of the plans have sixty per cent of the total enrollment. It was my impression that a IPA can succeed only if it is well marketed, tightly controlled, obtains favorable hospital rate contracts, and provides financial incentives to physicians to practice cost containment. Preadmission certification and peer review of appropriatness of care seems to be essential for economic success. Although these may be more palatable when physician-controlled, they will require a major loss of independence from current practices.

I also attended the Forum for Medical Affairs seminar on Nurse Practitioners and Physician Assistants. These speeches were good but the concepts were not novel. The GMENAC report on physician surplusses was never mentioned but it seemed to take the steam out of many of the remarks of the day.

At the meeting itself, Hampden was represented in the Massachusetts delegation by one delgate, John Ayres, one alternate delegate, myself, and the semi-official hostess of the New Enland caucus, Vivian Purdy. The proceedings were more subdued than in previous sessions. There was widespread optimism that the Republican victory will mean less government intrusion into the practice of medicine. Although President Hunter and others spoke of the challange and opportunity afforded by increased emphasis on private initiative, the A.M.A.delegates seemed to be anticipating a period of peace and

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status quo. This was reflected by a smaller calendar of 88 resolutions compared to 158 at the annual meeting last July. Caucus breakfasts still began at 7:00 a.m. but reference committee hearings were briefer and the pace of the House more relaxed. The sense of decreased urgency was underlined by the dramatic departure of President Hunter and Executive Vice President Sammons from the floor of the House to attend conferences in Washington at the request of Mr. Reagan.

The 1980 annual meeting had referred several difficult problems to the Board of Trustees for reports, including activities of the JCAH, education of handicapped children, and consultants to government agencies, stated that studies were in progress and would be reported later. One satisfying report was the resolution of the conflict between the A.M.A. and other organizations accrediting medical education. It is difficult to evaluate the effectiveness of last years A.M.A. withdrawal from LCCME, but the new structure has restored unity to the accrediation system on terms that appear mutually satisfactory.

Another major report noted that women physicians are not participating in organized medicine and offered nine positive recommendations to improve this defect. A survey showed that sixty per cent of women physicians are married, half to other physicians, and most of these have one or more dependent children at home. Eighty five per cent want the A.M.A. to endorse the Equal Rights Amendment and almost half would base their decision to join the A.M.A on this issue alone. As women progress toward the anticipated thirty threee per cent of the physician population, their special needs must be recognized. These include flexible training and retraining schedules, adequate and appropriate child care facilities, more attention to health issues of concern to women, and special leadership training programs. Dual-career marriages warrant relief from duplicate dues. Organized medicine must address these issues but a concensus could not be reached and the recommendations were referred to the Board of Trustees. One gain for women physicians was the appointment of Nancy Dickey to a vacancy on the judicial council. Nancy is a thirty year old family practitioner from Houston, Texas, who has been active in the A.M.A. since her residency.

The Medical Student and Resident Physician Sections were as active and affective as ever. They sponsored fourteen resolutions, nine

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of which were adopted. As usual they presented cogent arguments in a coherent, organized manner. Their most effective persuasion was directed against the Council of Medical Education recommendation for approval of "the Essentials of Accredited Residencies" developed by teh LCGME. The residents felt that "editorial changes" in the new guidelines appearing since the last approved draft has seriously weakened their education postion. All four of the other participants of LCGME has already approved the essentials and put considerable pressure on the delegation to do the same. Ther residents argued so well that the Board of Trustees changed its recommendation and the House of Delegates returned the document to LCGME for revision. It was an excellent illustration of democracy in action and a reminder that most medical organizations outside the federation lack a democratic forum. HDMS is losing a valuable stimulus by not involving the resident physicans in our area.

One problem which is bursting upon us is the influx of graduates from offshore medical schools which will begin next June. There are now eleven thousand Americans in foreign medical schools, most of them in New Mexican and Carribean for-profit schools. There is concern that many of them will not we well trained and present accrediting mechanisms may not be adequate to protect the public. State authorities, notably in New York, are moving quickly and the results may be unpleasant. No plan of action seems to be forthcoming from organized medicine.

Membership remains an unsolved problem. Despite the obvious need for a national organizating, over half of America's physicians do not belong to the A.M.A. Unless their apathy can be overcome, the effectiveness of our postition in national matters will be weakened. Careful financial management has postponed the dues increase predicted for this year. However, it will be necessary next year and that will probably cost the A.M.A. for members. We all understand the need for unity be we do not practice it.

The next two years will be a great opportunity for professional leadership in areas such as health planning, cost containment, distribution of medical care, assessment of technology, and integration of paraprofessionals. If we fail, it may prove to be our last opportunity to maintain the only national health system based on private practice. Individually we can do little in these areas, collectively we can do much. The A.M.A is the forum where your ideas can be translated into action I saw it done in San Francisco. □

Garry deN Hough, II, M.D.
Alternate Delegate from Massachusetts

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# CORONARY ARTERY DISEASE: *A Pediatric Problem*

True or false: a) Atherosclerosis is the major cause of death in the United States, with a mortality and morbidity annual cost of 28 billion dollars. b) Early changes of atherosclerosis are a common finding in three-year-old children. c) Risk factors for coronary artery disease in adults are frequently identified in children as well. d) Atherosclerosis and coronary artery disease are pediatric problems.

If you answered "true" to all of the above, give yourself a perfect score for the pre-test. Atherosclerosis causes nearly a million deaths yearly in this country, almost more than all other causes combined. The process is a lifelong one, and while the end products of myocardial infarction and stroke generally appear in older individuals, it appears clear that atherosclerotic changes begin very early in childhood.

By age three nearly all children have some degree of fat accumulation in the wall of the aorta, called fatty streaks and these also appear in the coronary arteries between age 15 and 20 years. Fatty streaks are ubiqutous in virtually all populations regardless of diet or incidence of coronary artery disease (CAD), and they bear no relationship to serum lipid levels. Whether they indeed are the precursors of true atherosclerosis is not yet proven, but it is generally believed that in populations with high CAD incidence they indeed do progress on to full-blown coronary atherosclerosis while in other groups without CAD they regress.

At age 20 elevated lesions called fibrous plaques begin to occur in the coronary arteries. These have a core of lipid-rich material surrounded by a capsule of smooth muscle and connective tissue. Some feel that even by this stage the atherosclerosis is irreversible; if so, it would seem that efforts at intervention in this process should obviously be prevention of the formation of fibrous plaques. Certainly they are common in young adults. Autopsies on casualties from the Korean and

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Vietnam wars (average age of 22 years) showed 45-77% of these young men had some degree of coronary atherosclerosis.

In time, the fibrous plaque becomes complicated by hemorrhage, ulceration, necrosis or thrombosis, and the process then clinically surfaces in the fifth decade with myocardial infarction, stroke, or peripheral vascular disease.

When one examines large populations of adults there are certain factors which consistently correlate in a continuous fashion with the risk of CAD. Age, sex, hypercholesterolemia, hypertension, diabetes mellitus, and cigarette smoking are major risk factors, while physical inactivity, high-anxiety personality traits, obesity, and hypertriglyceridemia are less certain factors. These risk factors might be the cause of atherosclerosis, or possibly a secondary manifestation of a more basic process that leads also to CAD. Of importance, most of these factors are potentially modifiable by change in lifestyle.

The line of thinking, then, that one would like to adopt would be: a) there are certain identifiable risk factors for CAD, b) CAD begins during childhood and adolescence, therefore c) altering risk factors in the pediatric years should be an important means of decreasing the incidence of CAD.

Unfortunately, whether this apparently logical approach would be effective - or even safe - is as yet unclear. This is particularly true regarding diet and cholesterol.

The equation one would like to prove is diet (high cholesterol and saturated fats) leads to elevated cholesterol in the blood and this in turn initiates CAD. In fact there is evidence in support of this concept. A small number of individuals born with hereditary defects in lipid metabolism - the familial hypercholesterolemias - have elevated serum fats and early coronary artery disease. There is a large literature on the experimental results of high-fat, high-cholesterol diets in animals, particularly the rhesus monkey, and these show production of atheromatous lesions which resemble those in humans both morphologically and chemically. Reversibility - or regression - of atherosclerosis has also been repeatedly shown in monkeys. And in human populations there is a consistent correlation between CAD incidence, serum cholesterol levels, and a high-cholesterol, high-fat, and high-calorie diet.

If we want to change our diet, lower serum cholesterol, and diminish the incidence of CAD, how low does the cholesterol need to be? That is, what is a normal, or ideal serum cholesterol? In Japanese adults, who have a low risk for CAD, serum cholesterols run 120-160 mg% during middle-age years while levels in a comparable age group in this country are 180-240 mg%. At birth the blood cholesterol is about 70 mg% in the typical American baby. By age two years it has risen to 150 mg% where it remains stable until the teenage years when it again begins to rise. So that already during the pediatric years cholesterol levels in this country are high compared to low-risk populations.

And these are just averages. Recent studies examining the incidences of CAD risk factors in children show that between the ages of five and fifteen years cholesterol levels of over 200 mg% are present in 10 percent. In essence, American children are all perhaps

hypercholesterolemic in relation to what might be considered optimal cholesterol levels. This presumably reflects the fact that the usual U.S. diet is high in cholesterol and fat (particularly saturated fats, which make up about 40% of our caloric intake).

To lower serum cholesterol a prudent modified low-fat diet has been recommended for adults that would lower serum cholesterol level of the average American by 15-25%. This includes restriction of egg intake (three per week); use of low-fat milk, polyunsatureated margarine, and corn oil; and substitution of fowl and fish for beef in meat dishes. This diet requires careful shopping and preparation as well as some reorientation of food preferences, but it's feasible and involves foods which are readily available and not expensive.

How does this relate to diet in infants? Commercially prepared formulas such as Enfamil and Similac are very low in cholesterol and high inpolyunsaturated fats, so these prepared formulas meet the criteria of the prudent diet. Breast milk has higher amounts of cholesterol and less unsaturated fats, and breast-fed babies have higher serum cholesterol levels than those who are bottlefed. There are animal studies that suggest this might actually be beneficial in that higher intakes of cholesterol in the newborn period might "gear up" the metabolic machinery to lower cholesterol levels later in life. This has not been verified in human babies, and, in fact, if one examines serum cholesterol levels in previously breast-fed and bottle-fed infants at several years of age they are the same.

In later infancy there is some concern that low-fat formulas might deprive children of a substantial caloric source. But beyond the age of two there would appear to be good reason to institute the modified low-fat diet.

Still, there is hesitation in making such a sweeping recommendation for all children. First of all, there are those who do not share the idea that coronary artery disease and atherosclerosis are related to diet. They argue that associations in epidemiologic studies do not necessarily imply cause and effect. As an example, tuberculosis was once thought by epidemiologists to be due to malnutrition. They claim that the aortic and coronary artery lesions produced by feeding fat to animals are not the same as in humans with CAD. Also, the majority of people with high cholesterol levels do not devleop CAD. Sweden consumes as much saturated fats as the U.S. but has a much lower rate of CAD. Eskimos consume a diet very rich in saturated fat and cholesterol yet have virtually no CAD. These dissenters note that there is no prospective primary study that clearly shows that lowering cholesterol through diet or drugs will prevent CAD.

So although there is no proof that the prudent diet for children will ultimately decrease the incidence of adult atherosclerosis, could it possibly do harm? There are a number of concerns, none of them proven: Gallstones are reported to occur more frequently in adults who consume large amounts of polyunsaturated fats. There are fears that low cholesterol intake in infancy might retard myelination of the centeral nervous system. There was a suggestion of increased incidence of gastrointestinal cancer in adult study groups with this diet. And there is concern that a really low-fat diet might lead to an increase in carbohydrate intake.

Putting this all together, what kind of recommendations can be made concerning diet in childhood as a means of preventing CAD? First of all, on this question alone it would seem no alterations are necessary in current feeding practices under the age of two years. The options over that age would be: 1) to screen all the children and place those with high serum cholesterol levels on the prudent diet, or because this is impractical and has obvious drawbacks, 2) recommend the prudent diet for the pediatric population as a whole. There is a third middle-of-the-road option: determine serum lipid levels on children "at risk" (parent or close relative with clinical CAD under the age of 50) and alter diets in those with elevated blood cholestrol levels. To quote the American Heart Association: "Although the evidence does not yet support the recommendation that cholesterol and saturated fat should be reduced in the diet of all children, the public should be advised that such modification appears safe and very likely to be beneficial."

Hypertension is clearly an important factor in the etiology of CAD and stroke. How an increase in blood pressure instigates atherosclerosis is not clear, but it presumably relates to stress on vessel walls causing increased permeability to lipids.

In the past it was generally believed that most hypertension in children was due to organic disease, an idea that originated from referral centers where secondary causes of hypertension were over-represented. Essential hypertension is now recognized as more common in childhood than previously realized. More recent studies indicate that essential hypertension may be identified as early as three years of age and commonly during adolescence. Blood pressure levels tend to run in families and children with hypertension are likely to come from families with hypertension. And studies with twins and adopted children have indicated that this aggregation is more genetic than environmental.

Little is known about the long-term implications of discovering elevated blood pressure in children. The concern, of course, is that this hypertension will persist into adulthood and predispose to CAD. The phenomenon of hypertensive children staying hypertensive is called "tracking" and if there were 100% tracking the task would be easy, because those children at risk for developing adult hypertension could easily be detected. Unfortunately, the data on tracking is scant and conflicting. It appears there is a general trend for tracking but children will not follow percentiles for blood pressure as clearly as they do for height and weight. Blood pressure variation is high, particularly in adolescents.

What factors that relate to adult hypertension might we be able to control during childhood? The relationship between obesity and hypertension has long been recognized, and the prevention of adiposity is clearly important.

There is suggestive but not conclusive evidence that salt intake plays a role in the development of essential hypertension. Heavy intake of salt is common in many countries with a hgh incidence of hypertension. In genetically predisposed animals salt feeding will cause marked increase in blood pressure. If one lowers the salt intake in hypertensive adults about one-third will experience a marked reduction in blood pressure, one-third a modest decline, and one-third no effect.

Against this association: those who are hypertensive do not necessarily eat more salt, there is no evidence that a low-salt diet will prevent hypertension, and there are some populations with low incidence of hypertension that eat large quantities of salt. The sum of all this is that heavy salt intake may cause or be contributory to hypertension in genetically predisposed individuals.

Salt appetite is acquired and the average American consumes approximately three times more than metabolic requirements. Decreasing salt intake therefore makes sense, the only implications being: 1( a change in the taste of food, and 2) reduction of iodine intake via iodized salt.

Obesity is a risk factor in adulthood for CAD, probably acting indirectly by its effect or raising blood pressure rather than promoting artherosclerosis per se. Whether controlling obesity during childhood will prevent adult obestiy is not clear, but since treating obesity once it has occured is often futile, prevention offers a more optimistic approach.

Other than psychologic problems, there appears to be no significant risk from obesity itself during the pediatric years. The important question then is will obese infants and children become obese adults? For infants most data indicate that while there is a trend for obesity persisting into adulthood, the majority of fat babies do not become fat adults. In older children, however, the correlation with adult obesity is much high. There is marked familial aggregation of obesity. That is, fat parents have fat kids. The relative roles of heredity and environment are not clear, but the latter obviously plays a very important part, for obesity in families extends to pets as well.

If we believe that by preventing infantile obesity we can prevent adult obesity, how should one go about doing this? Breast-fed babies do gain weight more slowly than bottle-fed, but if one looks at weight gain several years later there is no difference between the two, and the same holds true for early or delayed introduction to solid foods. So despite current emphasis placed on such measures, there is no evidence that they ''set'' weight control for later years.

Feeding skim milk will result in considerable less calorie intake and somewhat less weight gain. Skim milk has not been recommended, however, because of concern of lack of energy reserves, high protein and salt intake, and possible fatty acid deficiencies.

So, it turns out that the business of preventing obesity is nearly as discouraging as treating it: 1) we do not know if preventing childhood obesity will have any effect on adult obesity; 2) signalling out the obese infant for high-risk management has its drawbacks because most obese

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babies do not become obese adults; 3) abnormal obesity is difficult to define, and during the first year of life it is unclear what is an optimal and safe means of preventing excessive weight gain; and 4) ingrained family eating and exercise patterns are as difficult to modify before as after the fact of childhood obesity.

There is a clear relationship between cigarette smoking and CAD, and this has been verified by coronary arteriography and autopsy reports. The more one smokes, the higher the risk. The precise mechanism is unclear but appears to relate primarily to the effects of carbon monoxide on blood vessel walls as well as nicotine-stimulated catecholamine release.

The per capita cigarette use in the United States remains the highest in the world, but there has been a downward trend since the Surgeon General's report in 1964. For adult men the prevalence rate has decreased 25%. But for teenage girls the rate has increased dramatically, and during this time span those smoking a pack or more a day has quadrupled. Every day 3,2000 adolescents in this country between the age of 12 and 18 take up smoking.

Why do they do this? And what could we do to prevent it? It does not appear that educating youth to the medical ills of smoking will help. Surveys show that 85% of regular teenager smokers believe that smoking is harmful to health. Interestingly, one-half think they will not be smoking five years later.

Many of the social forces of parent models, peer pressure, and cigarette advertising are very difficult to counter. One approach that holds promise is educating elementary school children on means of coping with peer pressure before they are introduced to smoking. They are than "immunized" against getting started. Another hopeful thought is that studies indicate that adolescents do listen to and respect the opinions of the medical profession. It is our responsibility to let pre-teens and teens know exactly how we feel about smoking and health.

And, finally, there is growing evidence that physical fitness does have some effect in reducing the risk of CAD in adults. This may be a direct effect on coronary vessels or possibly by reducing other risk factors such as obesity and hypertension. Like all the other risk factors, then, it would make sense to promote a lifetime of vigorous physical activity beginning in childhood. Children are, in general, already physiologically quite physically fit, so a vigorous campaign to train children is not warranted. Rather we should be interesting children in lifelong athletic activities that improve cardiovascular fitness: running, swimming, bicycling, tennis and these kinds of sports should be an important part of physical education programs.

The kind of interventions for all the above risk factors create a new role for medical personnel. If any impact is to be made with preventitive cardiology, physicians need to become "life style counselors" to children and parents. Obviously, there is a great deal more to be learned about appropriate strategies for preventing CAD, but a start has been achieved. It will be an important responsibility for all physicians to remain abreast and involved in this crucial area of preventitive medicine. □

Thomas Rowland, M.D.

# *1981 Holidays For Your Information*

**The No Sunday Law Holidays in 1981 are:**

| | |
|---|---|
| January 15 | Martin Luther King, Jr.'s Birthday (Thursday) |
| February 16 | Washington's Birthday (Monday) |
| March 17 | Evacuation Day (Tuesday) |
| April 20 | Patriot's Day (Monday) |
| June 17 | Bunker Hill Day (Wednesday) |

**Veteran's Day**

Veteran's Day, November 11, is, in some respects a half-holiday. Rules which apply are:

- From midnight to 1 p.m., Sunday Law restrictions are in effect.
- Prior to 1 p.m., a permit is required for business and commercial activities.
  After 1 p.m., business and commercial activities may be conducted without a permit.

Business and commercial firms requiring employees to work after 1 p.m. must compensate them at time-and-a-half or a sum specified by a labor contract.

Manufacturing employees cannot be required to work on Veteran's Day (see above under ''Manufactureres''). However, manufacturing employees may work, if they desire, after 1 p.m. on Veteran's Day at regular rates of pay.

Following is some additonal general information regarding Massachusetts holidays which may be of interest.

**Alcholic Beverages**

Package Stores: state law prohibits the sale and delivery of alcoholic beverages on Memorial Day, Thanksgiving Day, and Christmas Day. The sale of alcoholic beverages for private use on all other legal holidays is permitted.

Restaurants and Taverns: the sale of alcoholic beverages is prohibited from 1 a.m. to 12 noon on Memorial Day and Christmas Day. (In Suffolk County, alcoholic beverages sales are prohibited from 2 a.m. to 12 noon on these same days.)

Hotels: on Christmas Day and Memorial Day, hotels may not sell alcoholic beverages until 1 p.m. On all other legal holidays, the sale of alcoholic beverages is limited to the hours between 8 a.m. and 1 a.m. The closing time is extended to 2 a.m. if the holiday falls on Monday through Friday. However, local licensing authorities may limit sales to the hours between 11 a.m. and 11 p.m.

**Transportation of Goods**

Goods may be transported on all legal holidays by obtaining a permit from either the community of origin or from the community of destination. Trucks and commercial vehicles may operate without a

permit in Massachusetts before 8 a.m. and after 1 p.m. on Veteran's Day.

**No Sunday Law Holidays**

On holidays which have no Sunday Laws, businesses and commercial activities may use their discretion as to whether or not to open.

Once again, several exceptions should be noted. These exceptions are:

- Government Offices: government offices must close on all legal holidays in the state.
- Manufacturers: manufacturers cannot require an employee to work in a mill or factory on any legal holiday. However, work which is absolutely necessary and is lawful on Sunday is allowed. Also, requiring or requesting an employee in a manufacturing or mechanical establishment to work in excess of the lawful limit in one day in order to make up time lost by a legal holiday is not legal and is punishable by a fine of up to $100.

**Special Notice for Retail Stores**

On November 10, 1977, Chapter 722 of the Acts of 1977 was signed into law modifying the Sunday Laws for retail stores for the time period between Thanksgiving and Christmas each year.

Retail stores may be open for business on the following Sundays: November 29; December 6, 13, and 20. Employees cannot be required to work. If they choose to work, compensation cannot be less than time-and-a-half. Alcoholic beverages cannot be sold by retail establishments on these days.

**Commemoration Days**

There will be four Commemoration Days each year when the Governor shall issue a proclamation. The four dates are: March 15, in honor of Peter Francisco; May 20, in honor of General Marquis de Lafayette; May 29, in honor of the birthday of President John F. Kennedy; and June 28, in honor of Saint Jean de Baptiste. □

# *AUXILIARY NEWS*

The Science Museum will spend part of our $500 donation to purchase kits to be used in the classrooms pre and post tour school groups through the heart room and other areas. We need another $1000 for Scholarship or we will have to drop two recipients. HELP!!! □

Audrey Rich,
Hippocrat Correspondent

# LETTER TO THE EDITOR:

Early in December, 1980, I learned that the Putnam Practical Nursing Program might be eliminted because of the constraints of Propostion 2½ . While there has been no official decision, there is a strong possibility that the principal of the Roger L. Putnam VTHS, Walter Stanton, will concur with the Superintendent of Schools, Dr. John Deady in such a recommendation if educational cuts are based solely on the priorities of kindergarten through 12th grade. That recommendation would then be brought before the School Committee for an official decision.

Proposition 2½ is going to necessitate drastic reductions in school budgets. However, a move to eliminate the practical nursing program would be a tragic mistake for the following reasons:

- the 30 year history of graduating qualified practical nurses
- 100% of graduates have passed state board licensing examinations
- 100% employment available for graduates
- the program completely fulfills the philosophy of vocational education

This is only a part of an outstanding record for educating and preparing nurses to meet community needs.

Another issue to be considered is the fact that the city is substantially reimbursed by the State and Federal Government for the funding of our program. Therefore, the budgeted cost of the practical nursing program is not what the city actually pays.

I would appreciate support in the form of letters to Dr. Deady and Walter Stanton urging them to consider the impact of their recommendation upon the community and its nursing needs at a time when a nursing shortage already exists. □

Joan Breitung, RN
Department Chairperson,
Practical Nursing Program
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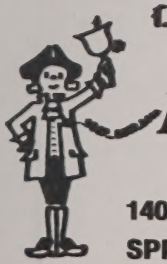

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